

**County of San Diego
Health and Human Services Agency (HHSA)
Mental Health Services**

SERVICE AUTHORIZATION FORM
Interpreter Services for Clients – Access and Authorization

A. PRIOR AUTHORIZATION**DATE of INITIAL REQUEST:** _____

TO: ☐ Interpreter's Unlimited

☐ Deaf Community Services

The County of San Diego, HHSA - Mental Health Services has authorized the following interpreting services:

Client's Name	Social Security No.	Date of Birth	Age	Language Requested

Requestor's Name: _____**Organization's Name:** _____**Program Name:** _____**Date & Time Service Requested:** _____

Clinical Need Type: _____ **Urgent (within 72 hours)**

_____ **Routine (by appointment)**

Approved By: _____

(Signature of Program Manager or designee) (Date)

Printed Name: _____**Address:** _____**Phone:** () _____ **FAX:** _____**B. TO BE FILLED OUT AFTER SERVICES HAVE BEEN PROVIDED**

This is to certify that the above service was provided on _____ **@** _____ **to** _____.

(Date) (Time : From) (Time: To)

By: _____

(Name of Interpreter)

Verified by: _____

(Clinician requesting service) (Date)

C. PLEASE SUBMIT THIS SERVICE AUTHORIZATION FORM TO:

Interpreter's Unlimited.....Fax Number: (800) 726-9822

Deaf Community ServicesFax Number: (619) 398-2490